STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505504	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Shores Health Center	9107 Fortuna Drive Mercer Island, WA 98040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42203 Based on observation, interview, and record review the facility failed to ensure residents were provided informed consent (ensuring an explanation of the risks and benefits was provided) for the use of a medical device for 1 of 1 (Residents 31) residents reviewed for positioning, and 1 supplemental resident (Resident 26). The failure to provide informed consent placed residents at risk for loss of autonomy. Findings included . <Resident 31> According to the 10/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 31 had diagnoses including a history of stroke and one-side paralysis. The MDS showed Resident 31had severe memory impairment, used a wheelchair for mobility, and depended on staff for most mobility needs. Observation on 12/10/2024 at 8:20 AM showed Resident 31 sitting at a table in the facility's [NAME] dining room. Resident 31 sat in a Tilt-in-Space wheelchair (a specialty wheelchair where the angle at which the user of the wheelchair is seated could be easily adjusted using handles behind the seat). The angle could not be adjusted by the chair's user, which had the potential to restrain the user. Review of Resident 31's record showed the record had a section where informed consent documentation was stored. There was no consent included showing Resident 31's representative was informed of the potential risks and benefits of the Tilt-in-Space wheelchair use. <Resident 26> According to the 11/06/2024 Admission MDS, Resident 26 was assessed with a severe memory impairment and had medically complex diagnoses including dementia and a condition where brain function affected mental processing. The MDS showed Resident 26 used a wheelchair. Observation on 12/12/2024 at 10:04 AM showed Resident 26 seated in the [NAME] dining room. Resident 26 was in a Tilt-in-Space wheelchair. Review of Resident 26's record showed no consent was included showing Resident 26 or their representative were informed of the potential risks and benefits of the Tilt-in-Space wheelchair use. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/16/2024 at 9:39 AM, Staff B (Director of Nursing) stated they expected the informed consent process to be completed with the potential risks and benefits explained prior to use of a device such as a Tilt-in-Space wheelchair. REFERENCE: WAC 388-97-0260.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44296 Based on observation, interview, and record review the facility failed to assess the resident's ability to self-administer their medications for 1 of 3 residents (Resident 29) reviewed. This failure placed residents at risk for overdose or under dose of medical treatment when self-administering of the wrong dose, frequency, route, and time. Findings included . Observations on 12/09/2024 at 8:40 AM and 12/12/2024 at 12:16 PM showed Resident 29 with an inhaler, a tube of ointment, and a nasal spray on their bedside table. Review of the 12/2024 Medication Administration Records (MAR) showed Resident 29 could keep their inhaler at the bedside. The MAR showed no authorization to keep the nasal spray or the ointment at the bedside. Review of Resident 29's medical record found no assessments were completed to ensure Resident 29 could self-administer their inhaler, nasal spray or ointment according to the physician's instructions. In an interview on 12/12/2024 at 2:16 PM, Resident 29 stated I have to use the inhaler all the time, I do not need anyone to tell me how to use it. I need it on the table because if I need it at 3:00 AM, I cannot wait 20 minutes for them to bring it to me. Resident 29 stated the staff did not provide them with instructions or have them demonstrate how to use the inhaler, the nasal spray, or the ointment. Resident 29 stated the nurses knew the medications were kept on the bedside table. In an interview on 12/12/2024 at 2:36 PM, Staff G (Registered Nurse) reviewed the physician orders for Resident 29. Staff G stated the orders showed the inhaler could be kept at the bedside, but the nasal spray and the ointment did not have a physician order to keep them at the bedside. Staff G immediately went into Resident 29's room and removed the nasal spray and the ointment. In an interview on 12/12/2024 at 2:41 PM, Staff B (Director of Nursing) stated there should be a physician order for all medications kept at the resident's bedside. Staff B stated residents should be assessed for their ability to self-administer medications if they are kept at the bedside. In an interview on 12/16/2024 at 9:14 AM, Staff B stated Resident 29 should have and did not have a self-medication assessment for the medications at their bedside. Staff B stated there was a change in the medical records a couple months ago which removed the resident self-medication administration assessment. REFERENCE: WAC 388-97-0440, -1060(3)(l).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review the facility failed to ensure residents had the appropriate Advanced Directive (AD) in place for 2 (Residents 31 & 2) of 3 residents reviewed for ADs. The facility failed to provide information indicating residents were informed, educated, or offered assistance to formulate an AD. This failure placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care. Findings included . <Facility Policy> According to the facility's September 2022 Advance Directives policy, if a resident had any ADs, the facility would obtain and maintain the document(s) to be readily available when needed to any facility staff. <Resident 31> According to the 10/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 31 admitted to the facility on [DATE] and had diagnoses including a history of stroke and one-sided paralysis. The MDS showed Resident 31 had a severe memory impairment. According to 07/01/2024 admission progress note, Resident 31's representative told Staff C (Social Worker) they were the resident's Durable Power of Attorney (DPOA - a legal surrogate for healthcare decision making). Resident 31's representative stated they would find and provide a copy of the DPOA paperwork. Record review showed no DPOA was on file for Resident 31. In an interview on 12/16/2024 at 10:27 AM, Staff C stated they inquired about AD paperwork upon admission and requested a copy for the records held at the facility, if they were in place. Staff C stated they documented efforts to obtain residents' ADs in admissions progress notes. Record review showed no further progress notes indicating any follow up to obtain the paperwork required to be maintained at the facility. 44296 <Resident 2> According to the 10/09/2024 Admission MDS, Resident 2 admitted to the facility on [DATE] and was assessed with intact memory. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed Resident 2 had a DPOA identified on their Face Sheet (a document listing a resident's personal information, contacts etc.). Record review showed there was no DPOA paperwork in place at the facility. Record review showed Staff C wrote a 10/03/2024 progress note showing Resident 2 told Staff C their relative had their DPOA paperwork. This note showed Staff C would reach out to the relative for a copy. There were no further progress notes indicating Staff C followed up regarding the DPOA paperwork. In an interview on 12/10/2024 at 1:23 PM, Resident 2 stated a relative was their DPOA. Resident 2 stated the facility knew they had a DPOA but was unsure of what efforts were made by the facility to obtain it. In an interview on 12/16/24 11:58 AM Staff C stated having AD paperwork in place was important so when a resident could not make their needs known, the facility would know whom to communicate regarding the resident's healthcare decision-making. Staff C stated they did their best to obtain AD paperwork, but it did not always happen. REFERENCE: WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(a-c).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to thoroughly investigate a fall for 1 (Resident 88) of 3 residents reviewed for accidents, and rule out abuse/neglect for 2 (Resident 23 & 33) of 3 sampled residents reviewed for abuse. Facility failure to complete thorough investigations placed residents at risk for further falls, potential abuse, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's Accidents and Incidents - Investigating and Reporting policy, all accidents and incidents involving facility residents should be thoroughly investigated. Review of the facility's September 2013 revised Skin Tears - Abrasions and Minor Breaks, Care of policy showed the facility would complete an in-house investigation of the cause of the skin injury. This policy showed when an abrasion/skin tear/bruise was discovered, an incident report would be completed. <Resident 88> According to the 12/06/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 88 admitted to the facility on [DATE] and was assessed with intact memory, and required supervision for transfers and moving from sitting to standing. The MDS showed Resident 88 was continent of urine and bowel. The MDS showed Resident 88 had medically complex diagnoses including a recent Urinary Tract Infection (UTI), Atrial Fibrillation (AFib - an irregular/rapid heart rhythm) and orthostatic hypotension (a condition where blood pressure drops when moving from lying to sitting or sitting to standing and cause dizziness). According to the 11/30/2024 Baseline Care Plan (CP), Resident 88 was identified to be at risk for falling. This CP did not identify any fall precautions. Review of the facility's December 2024 Incident Log showed Resident 88 fell on [DATE] and sustained an injury. According to a 12/03/2024 physician's progress note, Resident 88 fell at around 10 AM on that date. The physician noted Resident 88's fall was not witnessed, the resident bumped the back of their head with no loss of consciousness noted, and called family members who reported Resident 88 sounded confused. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation into the 12/03/2024 unwitnessed fall concluded Resident 88 fell while transferring from their bed to a chair independently. The investigation showed upon discovery of Resident 88's fall, the nurse on duty initiated neurological checks (periodic assessment for brain injury after head trauma). The investigation showed Resident 88's blood pressure was measured at 101/54 after the fall. The investigation's conclusion identified pertinent diagnoses from Resident 88's personal medical history including a UTI history and a prior history of fainting (related to their AFib diagnosis). The investigation did not identify Resident 88's orthostatic hypotension diagnosis as a potential risk factor in the fall. Observation on 12/10/2024 at 10:15 AM showed a document hung on the wall of Resident 88's room. The document showed staff began documenting neurological checks for Resident 88 on 12/06/2024 at 5:30 AM and had rows for nursing staff to do neurological checks every 15 minutes until 6:15 AM, then every half hour until 9:15 AM, with longer intervals after until a final row was scheduled for night shift on 12/10/2024. The last row completed by nursing staff was at 6:45 AM on 12/06/2024. Five neurological checks were completed and 18 were left blank. According to a 12/06/2024 progress note, at 5:30 AM a nurse heard Resident 88 crying out for help from their room. Resident 88 was found lying on the floor on their left side with their walker next to them. The note showed Resident 88 denied hitting their head, no new head trauma was noted, and the nurse initiated neurological checks. There was no further notes showing why neurological checks were not completed. Review of the facility's investigation into the 12/06/2024 unwitnessed fall showed Resident 88 stated they fell walking to the bathroom. The investigation showed Resident 88's blood pressure was low (99/43) immediately after the fall. The investigation's conclusion identified pertinent diagnoses from Resident 88's personal medical history including a UTI history and prior history of fainting. The investigation did not identify Resident 88's orthostatic hypotension diagnosis as a potential risk factor in the fall, despite the earlier observation that the resident's blood pressure was low at that time. In an interview on 12/16/2024 at 9:55 AM, Staff B (Director of Nursing) stated the investigation did not identify Resident 88's orthostatic hypotension could be a risk factor for the resident's falls. Staff B stated they did not know why nurses did not complete neurological checks after the 12/06/2024 fall. Staff B stated it was their expectation the neurological exams were completed. 44296 <Resident 23> According to the 10/02/2024 Significant Change MDS, Resident 23 was assessed with a severe memory impairment, and required substantial/maximal assistance to move in bed. The MDS showed Resident 23 had medically complex diagnoses including heart failure, peripheral vascular disease in their lower extremities, Diabetes, and dementia. The MDS showed Resident 23 had skin tears and required medical treatments for their skin. Observation on 12/10/2024 at 1:46 PM with Staff H (Registered Nurse - RN) showed Resident 23 had two scabbed areas on their left shin and a scab on their right shin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's incident reports from September through December 2024 showed a 09/08/2024 injury of unknown origin and an 11/07/2024 skin issue logged for Resident 23. Review of the 09/08/2024 injury of unknown origin investigation showed Resident 23 had a skin tear measuring six-by-three centimeters with bruising on their left lower leg. The aide stated they discovered the skin tear while providing care at 9:00 PM. The investigation showed Resident 23 told staff they did not know how the skin tear occurred. The investigation showed Resident 23 had increasingly fragile skin. The investigation did not identify a root cause of the skin tear. Review of the 11/17/2024 Skin Issue investigation showed the nurse's aide discovered a three-by-two-centimeter skin tear on Resident 23's right shin while providing care at 5:45 PM. The investigation showed Resident 23 could not describe how the skin tear occurred. The investigation did not identify a root cause of the skin tear. In an interview on 12/16/2024 at 9:14 AM, Staff B stated they expected all skin tears to be investigated. Staff B stated it was important to identify the root cause in order to prevent recurrence. Staff B stated the facility should have established root cause for Resident 23's skin tears. 46479 <Resident 33> According to the 11/05/2024 Admission MDS, Resident 33 had unclear speech, was sometimes understood by others, and could sometimes understand others. The MDS showed the brief interview for mental status could not be completed because the resident was rarely understood and had a short-term memory problem. This assessment showed Resident 33 did not have any current skin tears or skin problems. Observation on 12/09/2024 at 1:07 PM showed Resident 33 lying in bed. Resident 33 had two, undated foam bandages in place to their right forearm. A similar observation on 12/12/2024 at 10:54 AM showed Resident 33 in bed with two, undated foam bandages to their right forearm. An undated foam bandage was observed to the resident's left shin. Bloody discharge was observed soaking through the foam bandage on Resident 33's shin. In an interview on 12/12/2024 at 11:02 AM, Staff G (RN) stated they unaware of any skin treatments for Resident 33. Staff G reviewed Resident 33's physician orders and confirmed there were no treatment orders in place. In an observation and interview on 12/12/2024 at 2:32 PM, Staff B assessed removed the foam bandages and assessed the wounds to Resident 33's right forearm and left shin. Staff B asked Resident 33 if they knew what happened to their arm and leg, Resident 33 could not say. Review of Resident 33's physician orders on 12/11/2024 showed a 10/30/2024 order directing staff to perform a skin assessment for any new skin issues, notify the provider, obtain treatment orders, and complete an incident report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's progress notes showed an 11/01/2024 note indicating Resident 33 had a skin tear, the note did not specify the location of the skin tear. A 12/08/2024 progress note showed staff documented the resident had a foam dressing covering a skin tear on their right forearm. A 12/09/2024 progress note showed staff documented Resident 33 had a foam dressing to their right forearm. There were no details or other progress notes indicating how the injury occurred, if appropriate staff were notified, or that an incident report was completed regarding the injuries. Review of the facility's October 2024, November 2024, and December 2024 incident log showed staff logged three falls for Resident 33. A fall on 11/13/2024, 11/24/2024, and 11/25/2024. Review of the three fall investigations showed staff documented the resident did not obtain an injury from any of the falls. The facility's incident log showed there were no incidents logged for Resident 33 regarding the skin tears/injuries of unknown origin. In an interview on 12/16/2024 at 9:14 AM, Staff B stated Resident 33's injuries should be investigated at the time of occurrence. Staff B stated it was important to investigate Resident 33's injuries because the resident had impaired memory, and the facility needed to ensure the resident was not abused. REFERENCE: WAC 388-97-0640(6)(a)(b).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46479 Based on interview and record review, the facility failed to implement a system by which residents received required written notices at the time of transfer or as soon as practicable for 3 (Residents 28, 5, & 7) of 4 residents reviewed for hospitalization . Failure to ensure notification to the resident and/or the resident's representative of the reason for transfer in writing and in a language and manner they understood, placed residents at risk for a transfer not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> Review of the facility's October 2022 Transfer or Discharge, Facility-Initiated policy showed for emergent transfers, the resident and their representative would be provided a Notice of Transfer as soon as practicable. The notice would be provided in a form and manner the resident could understand. <Resident 28> According to the 07/30/2024 Discharge Minimum Data Set (MDS - an assessment tool), Resident 28 transferred to the hospital on 07/30/2024 with their return anticipated. Review of Resident 28's records showed no documentation a written notice of transfer was provided to the resident, or their representative as required. <Resident 7> According to the 06/02/2024 Discharge MDS, Resident 7 transferred to the hospital on 06/02/2024 with their return anticipated. According to the 06/16/2024 Discharge MDS, Resident 7 transferred to the hospital on 06/16/2024 with their return anticipated. According to the 07/24/2024 Discharge MDS, Resident 7 transferred to the hospital on 07/24/2024 with their return anticipated. According to the 10/13/2024 Discharge MDS, Resident 7 transferred to the hospital on 10/13/2024 with their return anticipated. Review of Resident 7's records showed no documentation a written notice of transfer was provided to the resident, or their representative as required. <Resident 5> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 10/22/2024 Discharge MDS, Resident 5 transferred to the hospital on 10/22/2024 with their return anticipated. According to the 11/14/2024 Discharge MDS, Resident 5 transferred to the hospital on 11/14/2024 with their return anticipated. Review of Resident 5's records showed no documentation a written notice of transfer was provided to the resident, or their representative as required. In an interview on 12/12/2024 at 11:50 AM, Staff A (Administrator) and Staff B (Director of Nursing) confirmed the facility did not have a process for providing written transfers to residents and/or their representative at the time of transfer. REFERENCE: WAC 388-97-0120(2)(a-d). . 42203 44296

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs requiring further assessment/treatment) assessment was accurately completed for 3 (Residents 33, 7, & 2) of 5 residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely services to meet their mental health needs. Findings included . <Facility Policy> According to the facility's revised March 2019 Admission Criteria policy, all new admissions were screened to determine if the resident met the criteria for mental disorders, intellectual disabilities, or related disorders. This policy showed if the resident met any of the criteria, they would be referred to the state PASRR representative for a Level II evaluation and determination. <Resident 33> According to the 11/05/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 33 admitted to the facility on [DATE] and had a diagnosis of depression. The MDS showed Resident 33 received an antidepressant medication during the assessment period. Review of Resident 33's physician orders showed a 10/30/2024 order directing staff to administer an antidepressant medication daily. Resident 33 had a 10/30/2024 physician order directing staff to monitor the resident for signs/symptoms of depression every shift. Review of Resident 33's 10/30/2024 Level 1 PASRR under the section Serious Mental Illness Indicators showed depression was not marked for Resident 33, indicating Resident 33 did not have a serious mental illness. In an interview on 12/13/2024 at 9:34 AM, Staff C (Social Worker) reviewed Resident 33's PASRR and records. Staff C confirmed the PASRR did not capture Resident 33's depression diagnosis and required correction. Staff C stated it was important to have accurate PASRRs to ensure resident needs could be met at the facility. 44296 <Resident 7> According to the 04/30/2024 Admission MDS, Resident 7 admitted to the facility on [DATE] and had a diagnosis of depression. This assessment showed Resident 7 received an antidepressant medication during the assessment period. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 7's physician orders showed a 10/21/2024 order directing staff to administer an antidepressant medication daily. Resident 7 had a 10/21/2024 order directing staff to monitor the resident for signs/symptoms of depression every shift. Review of Resident 7's 04/23/2024 Level 1 PASRR showed Resident 7 had anxiety. The PASRR did not capture Resident 7's diagnoses of depression. <Resident 2> According to Resident 2's 10/09/2024 Admission MDS, Resident 2 admitted to the facility on [DATE] and had diagnoses of anxiety, depression, and bipolar (mental disorder characterized by extreme mood swings). The MDS showed Resident 2 received antipsychotic, antianxiety, and antidepressant medications during the assessment period. Review of Resident 2's physician orders showed a 10/03/2024 order directing staff to administer an antianxiety medication twice daily, a 10/03/2024 order directing staff to administer an antipsychotic medication three times daily, and an 11/29/2024 order directing staff to administer an antidepressant once daily to the resident. A 10/03/2024 order instructed staff to monitor Resident 2 for signs/symptoms of depression, a 10/03/2024 order instructing staff to monitor the resident for signs/symptoms of behaviors of psychosis related to the antipsychotic medication, and a 10/03/2024 instructing staff to monitor Resident 2 for signs and symptoms of anxiety. Review of Resident 2's 10/03/2024 Level 1 PASRR completed by Staff C showed only Mood Disorders were marked. The PASRR did not capture Resident 2's anxiety diagnosis and the resident was not referred for a PASRR Level II evaluation. In an interview on 12/16/2024 at 11:51 AM, Staff C stated they were unaware of the new regulations regarding referring residents for Level II PASRR. REFERENCE: WAC 388-97-1915(1).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42203 Based on observation, interview, and record review the facility failed to develop and implement comprehensive Care Plans (CPs) for 5 (Residents 5, 31, 33, 7, & 23) of 12 sample residents whose CPs were reviewed. The failure to develop and/or implement comprehensive CP interventions left residents at risk for unmet care needs and other negative health outcomes. Findings included . <Resident 5> According to the 11/27/2024 5-Day Minimum Data Set (MDS - an assessment tool) Resident 5 had medically complex diagnoses including a heart condition that could cause fluid in the lungs. The MDS showed Resident 5 used supplemental oxygen upon admission and during the assessment look back period. Observation on 12/09/2024 at 2:52 PM showed Resident 5 had an oxygen concentrator and a nasal cannula (tubing to deliver supplemental oxygen to the nostrils.) The nasal cannula was resting on Resident 5's bedside table Record review showed an 11/21/2024 physician's order directing staff to provide Resident 5 supplemental oxygen at two liters per minute via a nasal cannula. Review of the 09/25/2024 comprehensive CP showed the facility did not develop a CP addressing Resident 5's supplemental oxygen use. There was no goal developed, and there were no directions for settings for the concentrator, or care and cleaning of the cannula and concentrator. In an interview on 12/16/2024 at 9:39 AM Staff B stated as Resident 5 had an order for and received supplemental oxygen, there should be an associated CP. Staff B stated facility nurses should have but did not develop an oxygen CP. <Resident 31> According to the 10/03/2024 Quarterly MDS, Resident 31 had diagnoses including a history of stroke and one-side paralysis. The MDS showed Resident 31 had severe memory impairment, used a wheelchair for mobility, and depended on staff for most mobility needs. The MDS showed Resident 5 did not receive a restorative nursing program (a program to help residents with range of motion or other impairments maintain their current function). Observation on 12/10/2024 at 11:05 AM showed Resident 31 lying in bed. The fingers on Resident 31's right hand were curled into the palm of their hand. Review of the 07/03/2024 comprehensive CP showed a Restorative Nursing Program . CP with a goal to maintain Resident 31's upper and lower range of motion on their right side. This CP did not indicate who was responsible for completion of the goal or specify a frequency for either the upper or lower body restorative program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/16/2024 at 9:56 AM, Staff B stated they were not sure if it was determined Resident 31 did not require a restorative program and that could be the reason why the restorative CP was incomplete. In an interview on 12/16/2024 at 10:42 AM, Staff J (Director of Rehabilitation) confirmed Resident 31 was on a restorative nursing program. 46479 <Resident 33> Review of Resident 33's 11/05/2024 Admission MDS showed the resident had diagnoses including a stroke resulting in difficulty with communication and diabetes (inability to control blood sugar levels). This MDS showed Resident 33 received anti-diabetic medications during the assessment period. Review of Resident 33's 12/11/2024 physician orders showed the resident had a 10/30/2024 order for an oral anti-diabetic medication to be administered once daily, a 10/31/2024 order for another oral anti-diabetic medication to be administered twice daily, an 11/19/2024 order directing staff to administer an injectable anti-diabetic medication at night, and an 11/21/2024 order directing staff to administer an injectable anti-diabetic medication three times daily. Review of Resident 33's 11/06/2024 Comprehensive CP showed a goal that the resident would not experience a fall with an intervention to monitor the resident for signs and symptoms of high or low blood sugar. Review of the Comprehensive CP showed there was no CP developed related to Resident 33's diagnoses of diabetes. There were no instructions to staff on what interventions to implement if the resident experienced high or low blood sugar, what labs should be monitored, or when and if the physician should be notified. 44296 <Resident 7> Review of the 10/21/2024 Readmission MDS showed Resident 7 was cognitively intact, had medically complex conditions including heart failure, kidney failure, and diabetes. The MDS showed Resident 7 required a diuretic (water pill) medication to manage their condition. In an observation and interview on 12/09/2024 at 2:47 PM, Resident 7 stated they had a lot of swelling in both feet. Resident 7 stated the nurses were not monitoring the swelling. Resident 7 stated the nurses gave them medication and the nurses must assume the medication was taking care of the swelling. Resident 7's representative removed the sheet and blanket to reveal Resident 7's bilateral swollen feet, ankles, and lower legs. Review of a 12/09/2024 Physician progress note showed Resident 7 had congestive heart failure, was prescribed a diuretic, was assessed with 1+ lower extremity edema, and trended towards fluid retention. The physician note showed the diuretic dose was doubled, a supplement was added, and orders for lab monitoring. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's 05/01/2024 Comprehensive CP showed no instructions to monitor, document, or report changes in their edema. In an interview on 12/16/2024 at 9:14 AM, Staff B stated Resident 7 should have edema monitoring on their CP and document monitoring in the medical record. Staff B stated they relied on the nurses to monitor edema, report changes to the physician, and prevent skin breakdown. Staff B stated the nurses could update CPs but usually did not. Staff B stated the nurses should notify the care manager or the Director of Nursing for CP updates. <Resident 23> Review of a 09/08/2024 and an 11/07/2024 incident report showed Resident 23 obtained skin tears on their shins. The reports showed Resident 23 did not know how the injuries occurred. Resident 23's skin was assessed as fragile and easily bruised or torn. The reports showed Resident 23 was to wear skin protective sleeves on their arms and legs to protect their skin. The report showed staff was educated to make sure Resident 23 was wearing the sleeves at all times. Review of the 05/21/2020 Comprehensive CP showed Resident 23 had fragile skin, had prior skin tears on their lower legs, and was at risk for skin tears on their legs. The CP showed Resident 23 should wear Tubi sleeve (a protective covering for skin) to cover their shins and protect from injury. Observation on 12/09/2024 at 12:24 PM showed Resident 23 was sitting up in bed with legs exposed, feet covered by blankets with the bedside table placed over the bed. Resident 23 was eating lunch from the tray on the bedside table. Resident 23 did not have Tubi sleeves on their lower legs. An observation on 12/09/2024 at 1:46 PM showed Resident 23 was sitting up in bed awake with both legs covered with a sheet and blanket. The bedside table was placed over Resident 23's lap. Staff H (Registered Nurse) removed the blankets from Resident 23's legs to reveal both shins. The left shin had two scabs on the shin. The right shin had a large scab. Staff H stated the scabs were healed and did not know how or when they were obtained. Resident 23 did not have any Tubi sleeves on their lower legs. An observation on 12/11/2024 at 7:02 AM showed Resident 23 lying in bed sleeping. The bedside table was next to the bed. Resident 23's right foot was visible outside of the blankets. Resident 23 did not have any Tubi sleeves on the lower right leg. In an interview on 12/16/2024 at 9:14 AM, Staff B stated Resident 23 needed protection of their skin. Staff B stated the staff should follow the care plan and Resident 23 should have been wearing the skin protective sleeves. REFERENCE: WAC 388-97-1020(1),(2)(a)(b).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 42203 Based on observation, interview, and record review the facility failed to complete a formal assessment prior to use of a Tilt-in-Space wheelchair (a specialty wheelchair with a seat and back that can be readjusted by a second party to reposition the user for comfort and/or pressure relief) for 1 of 2 residents (Resident 26) reviewed for accommodation of needs, and 1 of 1 residents (Resident 31) reviewed for positioning. The failure to ensure residents' Tilt-in-Space wheelchairs prior to use placed residents at risk for use of an inappropriate wheelchair, discomfort, and loss of bodily autonomy. Findings included . <Facility Policy> According to the facility's January 2020 Assistive Devices and Equipment policy, the facility would provide certain mobility equipment including wheelchairs to residents needing mobility assistance. The policy showed equipment recommendations would be made based on the comprehensive assessment and documented in the resident's Care Plan (CP). The policy showed an order to decrease the risk of avoidable accidents, to the extent possible, the appropriateness of the resident's condition would be assessed for determining the safest device, and for personal fit. <Resident 26> According to the 11/06/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 26 was assessed with severe memory impairment and had medically complex diagnoses including dementia and a condition where brain function affected mental processing. The MDS showed Resident 26 used a wheelchair. The MDS showed Resident 26 required partial-to-maximal assistance with mobility. Observation on 12/09/2024 at 1:34 PM in the [NAME] dining room showed Resident 26 sitting at the dining table. Resident 26 was in a Tilt-in-Space wheelchair. The chair was labeled with another resident's name and room number. Record review showed there was no documentation that showed the facility assessed the suitability of a Tilt-in-Space wheelchair for Resident 26. Record review on 12/16/2024 showed the at risk for falls . CP included an intervention to assist Resident 26 with mobility using their Tilt-in-Space wheelchair for locomotion. Resident 26's comprehensive CP did not include any other interventions for the Tilt-in-Space wheelchair, did not explain why Resident 26 needed a Tilt-in-Space wheelchair, and did not include directions for appropriate use including positioning. In an interview on 12/12/2024 at 10:07 AM, Staff B (Director of Nursing) stated wheelchair assessments were completed by the facility's therapy department. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/16/2024 at 9:09 AM, Staff I (Physical Therapist) stated when residents discharged from therapy, the facility matched the resident with a chair of the appropriate size, but when a resident's needs were more specific, the facility worked with an Assistive technology provider. Staff I stated the purpose of a Tilt-in-Space wheelchair was to assist with redistributing weight for residents who needed periodic weight redistribution and could not redistribute their own weight. Staff I stated perhaps directions for use of the Tilt-in-Space wheelchair should be included in the CP. Staff I stated documentation of the assessment of the Tilt-in-Space wheelchair might be in the chart. Staff I stated in terms of a formal assessment of a Tilt-in-Space wheelchair for a resident, it was a matter of knowing what the resident needs. Staff I stated they would provide further documentation of the assessment process for Resident 26. No additional documentation was provided. <Resident 31> According to the 10/03/2024 Quarterly MDS, Resident 31 had diagnoses including a history of stroke and one-side paralysis. The MDS showed Resident 31 had severe memory impairment, used a wheelchair for mobility, and depended on staff for most mobility needs. Observation on 12/12/2024 at 10:04 AM showed Resident 31 seated in the [NAME] dining room. Resident 31 was in a Tilt-in-Space wheelchair. Record review showed there was no documentation that showed the facility assessed the suitability of a Tilt-in-Space wheelchair for Resident 31. Record review showed Resident 31's comprehensive CP provided instructions to use a Tilt-in-Space wheelchair for locomotion but did not explain why Resident 31 needed a Tilt-in-Space wheelchair, and did not include directions for appropriate use including positioning. In an interview on 12/16/2024 at 9:09 AM, Staff I stated they would provide any further documentation they could locate of the assessment process for Resident 31's. No additional documentation was provided. REFERENCE: WAC 388-97-1060(1).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46479 Based on observation, interview, and record review the facility failed to ensure medications and biologicals were secured for 3 (Residents 14, 29, & 88) of 12 sample residents. The failure to ensure medications were not left at the bedside with residents not assessed to be able to self-medicate placed residents at risk for receiving the wrong medications, incorrect dosages, and non-assessed, self-administration of medications by residents. Findings included . <Resident 14> Observation on 12/09/2024 at 9:32 AM showed Resident 14 lying in bed with their over-the-bed table across their lap. A bottle of lubricating eye drops was on the table next to them. Observation on 12/12/2024 at 2:19 PM showed Resident 14 lying in bed with their over-the-bed table across their lap. A medication cup containing two, white, oblong pills were observed as well as a bottle of lubricating eye drops sitting on the table. In an observation and interview on 12/12/2024 at 2:28 PM, Staff G (Registered Nurse) went to Resident 14's room and confirmed the medications at bedside. Staff G stated they were supposed to stay with the resident until the resident took the medications, but they did not. Review of Resident 14's records on 12/12/2024 showed no assessments or orders indicating the resident was able to self-administer or keep medications at their bedside. <Resident 29> Observation on 12/09/2024 at 8:40 AM showed Resident 29 with a tube of prescription ointment used for skin irritation, a prescription nasal spray, and a prescription inhaler at their bedside. Similar observations were made on 12/12/2024 at 2:16 PM. In an interview at that time, Resident 29 stated staff did not assess their ability to properly use the inhaler. In an interview on 12/16/2024 at 9:14 AM, Staff B (Director of Nursing) stated residents should have physician orders to keep medications at their bedside. Staff B stated staff should complete an assessment to ensure residents could correctly and safely self-administer medications. <Resident 88> Observation on 12/10/2024 at 1:16 PM showed a tube of oral anesthetic gel on the resident's bedside table. Similar observations were made on 12/11/2024 at 12:50 PM. In an interview on 12/16/2024 at 9:39 AM, Staff B stated Resident 88 should not have the oral anesthetic gel on their bedside table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1300(2). . 44296 42203